Notice to HMSA HSTA Members

Dear Member:
You may have received a letter from HMSA about the termination of your HSTA VEBA coverage. Please note that the letter is simply an acknowledgement that your health plan coverage is transferring from the HSTA VEBA Trust plan administered by HMSA into the EUTF plan, also administered by HMSA. HMSA will continue to administer your health plan and you will experience no gap in coverage.

The letter, which is mandated by the Health Insurance Portability and Accountability Act (HIPAA), provides documentation of your plan coverage under the HSTA VEBA Trust plan administered by HMSA, and confirms that your HSTA VEBA coverage is terminating since your coverage is now through EUTF.

For assistance and more information, please visit HMSA's website at hmsa.com/eutf. You may also call HMSA Customer Relations at 948-6111 on Oahu or 1 (800) 776-4672 toll-free on the Neighbor Islands from 8 a.m. to 4 p.m., Monday through Friday. The best days to call for the shortest wait times are Thursdays and Fridays.

IMPORTANT DOCUMENT
KEEP FOR FUTURE USE

2510 Member ID:
Group Nbr:

Dear Member:

The Health Insurance Portability and Accountability Act ("HIPAA"), enacted on August 21, 1996, requires us to provide you with a Certificate of Coverage ("Certificate"). Generally, we are required to provide you with a Certificate upon termination of your health plan coverage or upon request. You may also receive a Certificate if there are major changes to your coverage or changes in your membership number. You will find your Certificate on the reverse side of this letter.

The Certificate indicates the length of health plan coverage you have earned as a beneficiary of the above health plan. With this information, health plan sponsors and/or issuers may be required to provide you with health plan coverage and may be further required to apply the length of coverage under this plan toward reducing any pre-existing condition exclusion periods they may have under their plan. Enclosed is a Statement of HIPAA Portability Rights that further explains your rights under HIPAA.

Please review your Certificate and contact us immediately if you believe there is an error in the information provided.

Please call our Membership Service Department at (808) 948- if you have any questions or need any additional information regarding the Certificate.

Sincerely,

Tracey S. Villeza
Manager
Enrollment

Name, address, and telephone number of issuer responsible for providing this Certificate:

CERTIFICATE OF COVERAGE

Date of this certificate: Certificate No.

Name of health plan:

Subscriber Name:

Subscriber number:

Name of dependents to whom this certificate applies:

A check below indicates that the individual(s) identified has at least 18 months of creditable coverage (disregarding periods of coverage before a 63 day break):

CHECK HERE: ☐

Activation Date: _____

End Date: _____

If less than 18 months of creditable coverage and this coverage is under an individual plan, indicated below is the date a substantially completed application was received:

Date: _____

For further information call: (808) 948-

* This date does not account for any waiting period applied by the subscriber's employer, if any. For further information concerning any waiting period please contact your employer directly.

Note: Separate certificates will be furnished if information is not identical for the participant and each dependent.

Statement of HIPAA Portability Rights

IMPORTANT – KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan.

Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusion. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior credible coverage. Most health coverage is credible coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of credible coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any credible coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have the right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMO's to provide additional protections to individuals in that state.

For more information. If you have questions about HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publications hotline at 1-800-633-4227, (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages- Health Elaws, or http://www.cms.hhs.gov/hipaa.